DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
BOX 788250
MARINE CORPS AIR GROUND COMBAT CENTER
TWENTYNINE PALMS, CALIFORNIA 92278-8250

IN REPLY REFER TO:
NAVHOSP29PALMSINST 5890.1B
Code 0905
24 April l995

NAVAL HOSPITAL TWENTYNINE PALMS INSTRUCTION 5890.1B

From: Commanding Officer

Subj: THIRD PARTY LIABILITY PROGRAM

Ref: (a) Title 42, United States Code 2651-2653
(b) Title 32, Code of Federal Regulations, Parts 199 and 220
(c) JAGMAN 20, 2001 to 2080
(d) DoD Instruction 60l0.l5
(e) Title 10, United States Code 1074, 1076-1078 and 1095
(f) NAVMEDCOMINST 6320.3B

Encl (l) Third Party Liability Questionnaire, NAVHOSP29PALMS Form 5890/l

l. Purpose. To establish basic procedures for identifying and reporting potential Third Party Liability (TPL) cases where the Department of the Navy may have a claim under the Medical Care Recovery Act (MCRA).

2. Cancellation. NAVHOSP29PALMSINST 5890.1A.

3. Background. References (a) through (f) require the investigation and reporting o any injury or disease suffered by an eligible military beneficiary for which another person may be legally liable. As a result of the law, the Department of the Navy may attempt to recover the cost of inpatient and/or outpatient treatment given at the government's expense where the treatment was necessitated by the negligence or unlawful actions of a third party.

4. Discussion. Any non-combat injury to any patient authorized to receive care at a Naval Hospital, or in a civilian hospital at government expense, may have MCRA possibilities. Diseases are included when caused by another person, however, the possibility of such cases arising is remote. Other injuries such as those resulting from slip and fall accidents, catastrophic events such as plane crashes, accidents on private property, assaults and defective products may also give rise to potential recovery. It is recognize that the key to conducting an effective TPL program is consistent, accurate and early identification of potential TPL cases.

5. Action

a. Naval Legal Service Office (NLSO), San Diego shall receive, investigate and initiate MCRA action, when indicated, on all reports of potential TPL cases originated by this hospital. The Judge Advocate General (JAG) has delegated responsibility to NLSO, San Diego to act as JAG designee for the area in which the Naval Hospital, Twentynine Palms is located.

b. Head, Patient Administration Department shall:

(1) Be responsible for coordinating the TPL program at this hospital.

(2) Review all inpatient admissions to identify and process possible TPL cases.

(3) Ensure each patient admitted that could possibly result in a TPL case be given a questionnaire (enclosure (l)) and ensure the questionnaire is returned for discharge.

(4) Review all requests for medical records for possible TPL implications, especially subpoenas, requests from attorneys and insurance companies.

(5) Train required personnel to identify potential inpatient and outpatient TPL claims, NLSO reporting and other proper disposition of Command originated claims and information.

c. Head, Emergency Medicine Department shall:

(l) Ensure that all Emergency Treatment Records (ETRs) are reviewed for possible TPL cases and forwarded to Head, Patient Administration Department for appropriate action.

(2) Ensure all department personnel are trained to identify potential TPL cases.

d. Head, Military Sick Call and Clinical Department Heads shall:

(l) Ensure that all possible TPL cases seen in the clinic are identified and reported to the Head, Patient Administration Department for appropriate action.

(2) Ensure all department personnel are trained to identify potential TPL cases.

e. Head, Fiscal Department shall:

(l) Ensure all possible TPL cases are referred to NLSO, San Diego for review and appropriate action. This includes any cost information that is required by NLSO.

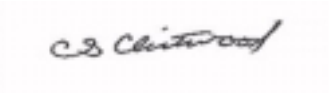
(2) Ensure NLSO, San Diego has the proper appropriation data (line of accounting) which will be used to credit Naval Hospital, Twentynine Palms for revenues received.

(3) Track revenues earned and provide detail as to how TPL revenues are utilized by the Command.

(4) Assist the Head, Patient Administration Department in the coordination of and the training for the TPL program at this Command.

6. New or Revised Forms. Third Party Liability Questionnaire, NAVHOSP29PALMS Form 5890/1, is being adopted in accordance with this instruction and may be obtained through Central Files.

7. Applicability. This instruction is applicable to all personnel aboard Naval Hospital, Twentynine Palms, California.



C. S. CHITWOOD

Distribution:
List A

THIRD PARTY LIABILITY QUESTIONNAIRE
PRIVACY ACT STATEMENT

1. Authority.
Privacy Act of 1974, 5 U.S.C., 552(a) (1982).
Medical Care Recovery Act, 42 U.S.C., 265l-53 (l982)
Navy Affirmative Claims Regulations, 32 C.F.C., 757 (l984)
Department of Justice Regulations, 28 C.F.R., 43 (1943)

2. Principal Purpose. To provide information for the collection of Medical Care Recovery Act claims against third persons who cause injuries to other individuals who were given medical care at a government health care facility or at government expense.

3. Routine Uses. Information given by the injured persons who received treatment at government expense or at a government health care facility is used to recover the reasonable value of the medical care from the individual who caused the injury. The information is also used to prepare reports to the Department of Justice and the Department of the Navy.

4. Mandatory Disclosure and Consequences of refusal to Disclose. Federal law requires the injured party to provide the requested information. 32 C.F.R., 757.5 (l984); 28 C.P.R., 43.2 (1984); and 42 U.S.A., 2651 (a) (1982).

If the requested information is not given, the United States Navy may force disclosure by court action. The United States Navy may also require the injured person to assign all claims for medical expense of the medical treatment to the United States Navy for collection.

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE INSTRUCTIONS AND I DO FURTHER CERTIFY THAT THE ANSWERS ARE TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE AND COMPLETE. I HAVE ALSO READ AND UNDERSTAND THE CONTENTS OF THE PRIVACY ACT STATEMENT.

_____ _____
(SIGNATURE) (DATE)

(PLEASE PROCEED TO THE NEXT PAGE)

THIRD PARTY LIABILITY QUESTIONNAIRE

Instructions: Please answer all questions as completely as possible. When giving names and addresses, please provide complete addresses, including street number, city, state and zip code. If more space is required for any requested information, please use the reverse side of the sheet.

PLEASE PRINT - - RETURN COMPLETED QUESTIONNAIRE - - DO NOT SEPARETE

1. Name of person injured _____
Home address _____
City _____ State _____ Zip Code _____
Telephone (Home) (___) ____-_____ (Work) (___) ____-_____
Social Security Number _____ Date of Birth _____

(a) If Military Member, current duty station _____
_____ Rank/Rate _____

(b) If Dependent:

Sponsor's Name _____
Sponsor's Social Security _____
Sponsor's Branch of Service _____ Active____ Retired____
Sponsor's Duty Station if Active Duty or home address if Retired _____
Relation to Sponsor _____
Dependent's Social Security Number _____
Dependent's Date of Birth _____

2. Date of accident/incident _____ Time _____
Exact Location (street, avenue, freeway exit, city, state)
_____
_____

(a) Was this accident/incident investigated by a law enforcement agency Yes ___ No ___ If yes, Name and address of agency 9i.e. city police, county sheriff's department, highway patrol) _____
_____ Report Number, if known _____

(b) Circumstances of injury or accident:

(1) Were injuries sustained in a Motor vehicle accident:
Automobile _____
Motorcycle _____
Truck/van _____
Bicycle _____
Public transpiration (bus, train, cab) _____

(PLEASE PROCEED TO THE NEXT PAGE)

(2) Did this accident/incident take place at:
Home _____
School _____
Public Place (i.e. store, restaurant) _____
(3) Was the injured party a pedestrian? Yes __ No __

(4) Other type of incident 9i.e. gunshot, stabbing, fight, dog bite, food poisoning, medical malpractice)
_____

(c) Describe in your own words the circumstances of how this accident/incident took place:

_____
_____
_____

3. Names, locations and dates of treatment received, including all military and civilian hospitals, clinics or other health facilities.

Date(s)	Facility/Doctor	Address/Location

Please indicate if treatment was inpatient or outpatient:

_____
_____

If documentation relating to this incident is available in the outpatient health record, please provide copies.

If injured party is a department or retired service member, did CHAMPUS pay for treatment received? Yes ___ No ___ If Yes, who provide the medical treatment? _____
_____

4. Name and address of party responsible for this accident And/or incident:

Name _____
Address _____
City _____ State _____ Zip Code _____
Telephone (Home) (___) _____-_____ Work (___) _____-_____

(PLEASE PROCEED TO THE NEXT PAGE)

Does the responsible party have insurance? Yes ___ No ___
If yes, provide the below information:
Name of Insurance _____
Address _____
_____
Policy number: _____ File/Claim number: _____

If the injuries sustained were the result of a motor vehicle accident, other party's :
Social Security Number: _____ Date of Birth _____
Drivers license _____ State _____

If the injuries sustained were the result of a motor vehicle Accident, other party's:
Social Security number _____ Date of Birth _____
Drivers license _____ State _____

5. If the injuries sustained were the result of a motor vehicle accident, were you the: Driver ____ Owner ____ Passenger ___

Owner: Name _____ Rank/Rate: _____
Address and/or Duty Station: _____
Social Security Number: _____
City _____ State _____ Zip Code _____
Telephone (Home) (___) ____-_____ (Work) (___) ____-_____
Insurance information:
Company Name _____
Address _____
Policy number: _____ File/Claim number: _____
Type of insurance coverage:
Liability _____ Amount _____
Uninsured Motorist _____ Amount _____
Medical Payment _____ Amount _____
Personal Injury Protection _____ Amount _____

Driver: Name _____ Rank/Rate _____
Address and/or Duty Station: _____
City _____ State: _____ Zip Code _____
Telephone (Home) (___) ____-_____ (Work) (___) ____-_____
Insurance information:
Company name _____
Address _____
_____
Policy number: _____ File/Claim number: _____
Type of insurance coverage:
Liability _____ Amount _____
Uninsured Motorist _____ Amount _____
Medical Payment _____ Amount _____
Personal Injury Protection _____ Amount _____

(PLEASE PROCEED TO THE NEXT PAGE)

6. Do you or any member of your family have any type of insurance covering your injuries? Yes ___ No ___ If yes, Provide the below information:
Name of Insurance _____
Address _____
_____
Name of Policy Holder: _____
Policy Number: _____

7. Did any military members, dependents, and/or retired members sustain injuries as a result of this accident/incident?
Yes ___ No ___ If yes, **provide the name, address, duty station, rank, and social security number.**

(a) _____
_____
_____ SSN _____

(b) _____
_____
_____ SSN _____

(c) _____
_____
_____ SSN _____

8. Have you obtained an ATTORNEY for the recovery of damages?
Yes ___ No ___ If yes, please provide the information requested below:

Name _____
Address _____
City _____ State _____ Zip Code _____

9. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL AND MILITARY RECORDS IN CONNECTION WITH THIS CASE.